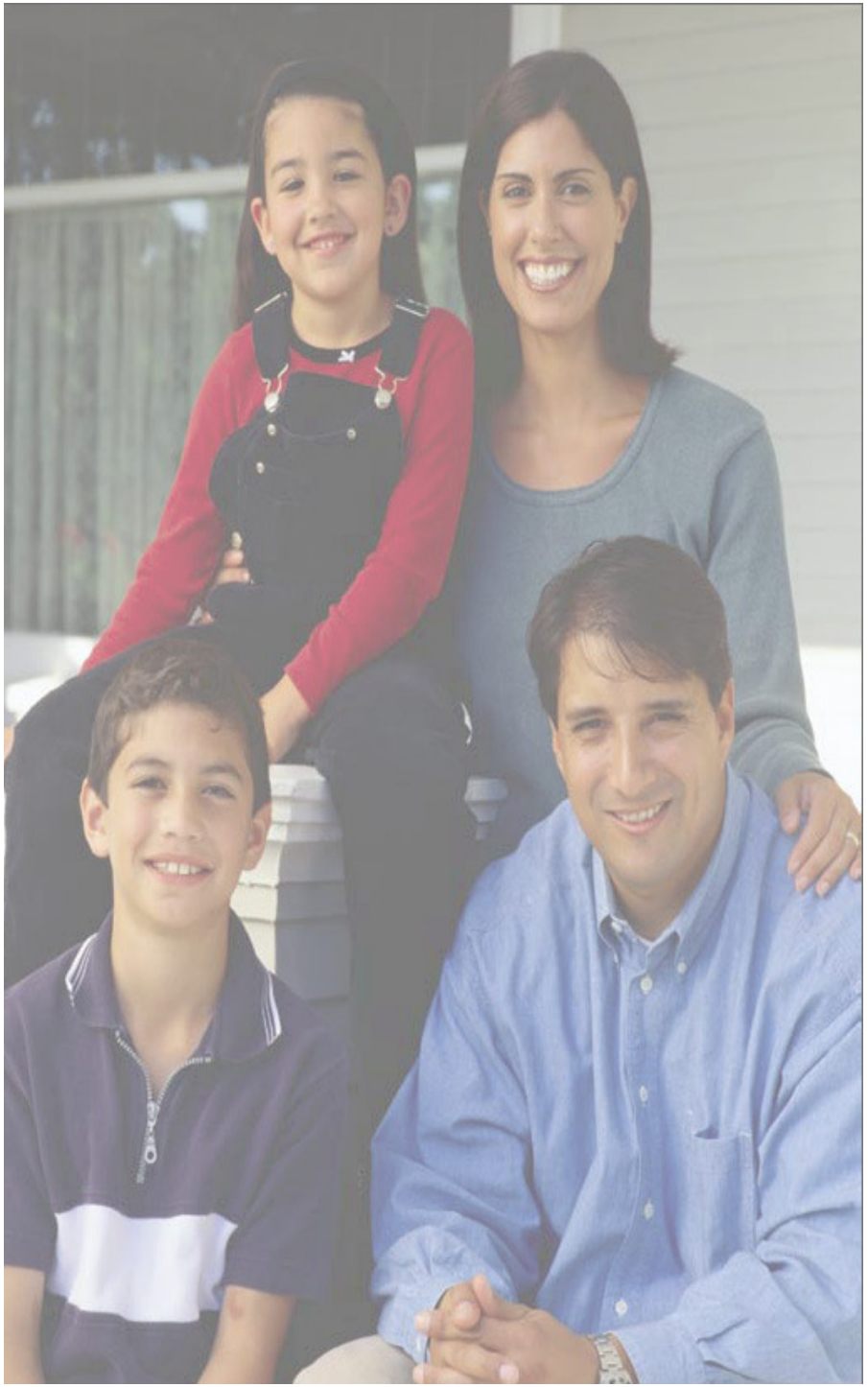


MCM Commission

Nick Toumpas

NH Department of Health and Human Services

New Hampshire MCM MEDICAID CARE MANAGEMENT

September 4, 2014

Agenda

- Monthly Enrollment Update
- Key Program Indicator Report Update
- Update on Key Operational Issues
- Other Updates
- Q&A from Commission and Public

Setting the Context

Care Management Program

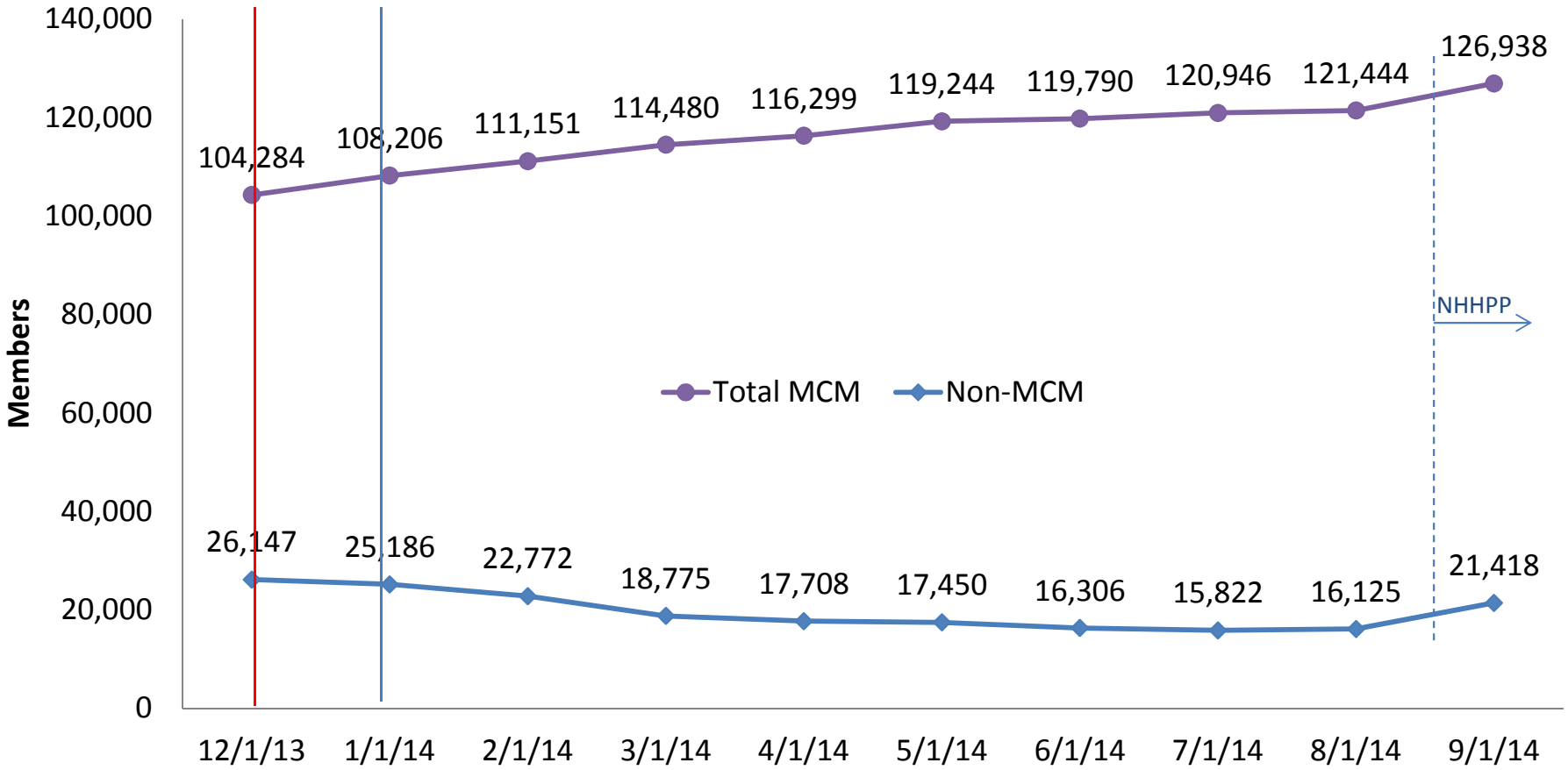
@ 8 Months

Guiding Principals of NH MCM

- **Whole person management and care coordination**
  - **Foundation for Medicaid transformation**
- **Increase quality of care – right care, at the right time, in the right place to improve beneficiary health and quality of life**
- **Payment reform opportunities**
- **Budget predictability**
- **Purchasing for results and delivery system integration**

ENROLLMENT UPDATE

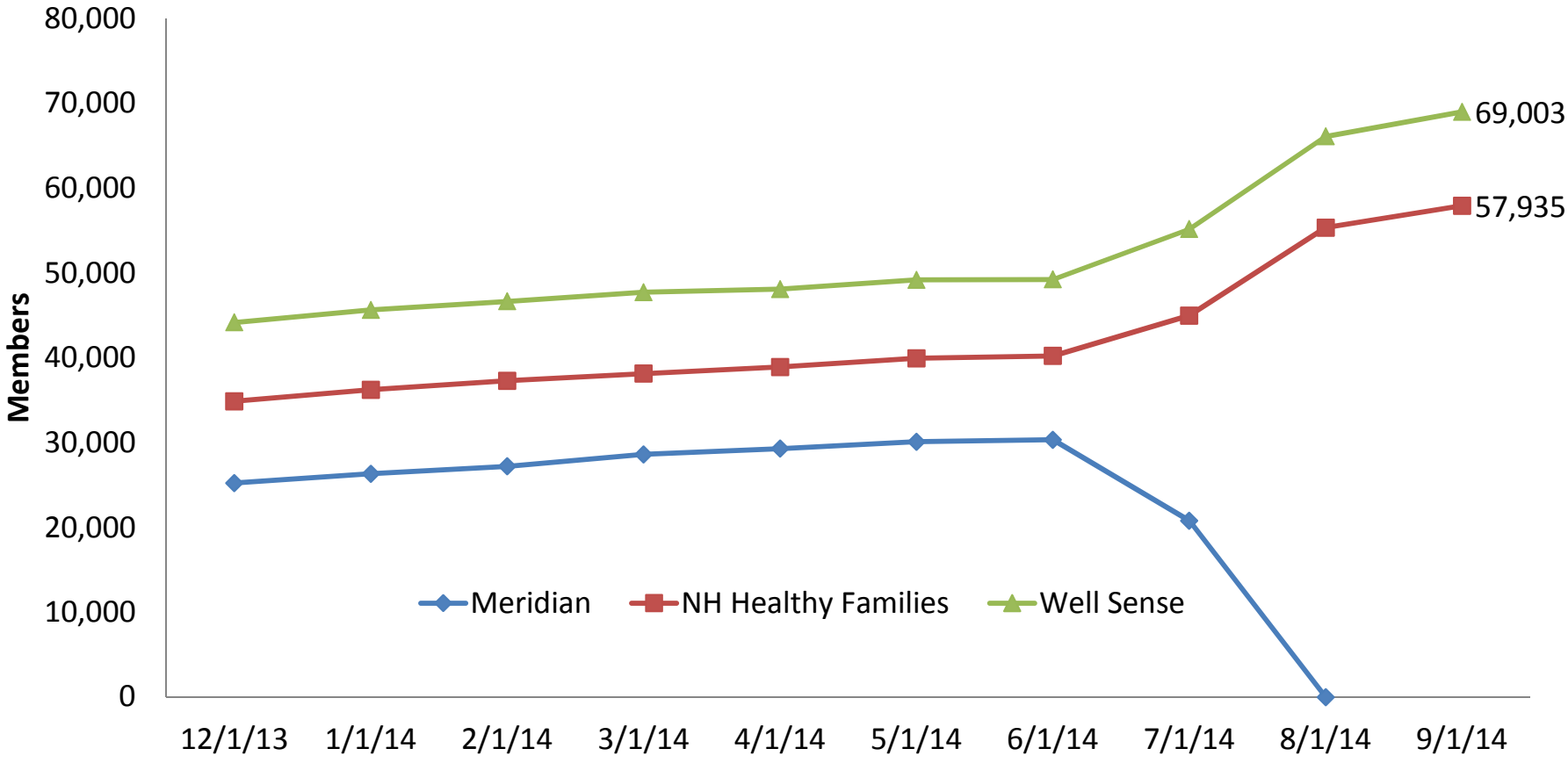
NH Medicaid Care Management Enrollment, 12/1 – 9/1



Note: Non-MCM Includes retroactive enrollment and excludes members who only have Medicare savings plans (e.g., QMB)

Source: NH MMIS as of 9/2/14 for most current period; Data subject to revision.

NH Medicaid Care Management Enrollment by Plan, 12/1 – 9/1

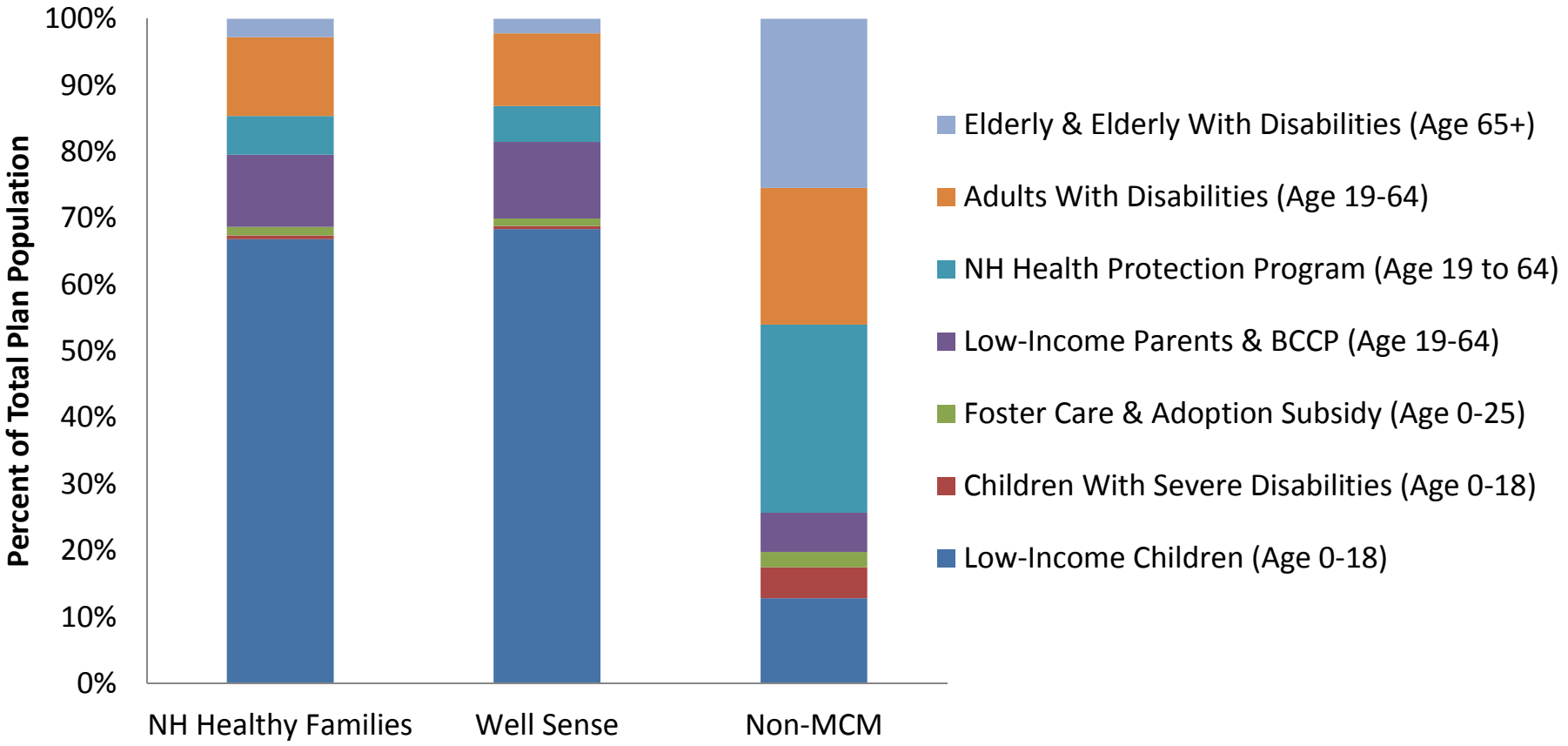


Note: Non-MCM Includes retroactive enrollment and excludes members who only have Medicare savings plans (e.g., QMB)

Source: NH MMIS as of 9/2/14 for most current period; Data subject to revision.

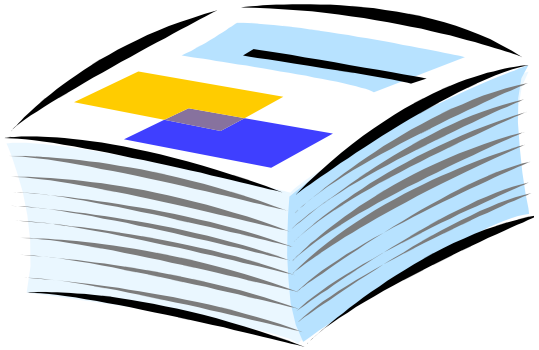
NH Medicaid Care Management by Eligibility Group, 9/1/14

Health plan as a percent of total eligibility group population



Source: NH MMIS as of 9/2/14; Data subject to revision.

Key Performance Indicator Report



NH Medicaid Quality Program Overview

- Quality Perspectives
  - Health and Healthcare Services
  - Consumer Experience
  - Business Operations
- Inputs from
  - DHHS
  - EQRO
  - MCOs
- Outputs
  - Reports (ex: Key Indicator report)
  - MQIS website (late Fall 2014)
  - Quality Improvement projects and programs

MCM Key Indicators Report

- **DHHS tool for monitoring program performance**
- **Organized by various domains that represent indicators of the health of the program**
  - **This provides foundation for comparison of the two MCOs.**
- **Some indicators and metrics have prescribed benchmarks such that performance and compliance is illustrated.**
- **Some indicators require a trend in order to show performance and compliance over time.**
- **Some indicators are reported monthly, some quarterly and still more are reported annually.**
- **User Guide is integrated into the body of the report**

MCM Key Indicators

Metrics in the Key Indicators Report include:

- Access & Use of Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievance & Appeals
- Preventative Care
- Chronic Medical Care
- Behavioral Health Care
- Substance Use Disorder Care
- General

Access and Use of Care
Notable Results

- A high number of member calls requesting assistance finding a doctor would be expected at the beginning of a new program like the MCM program. (Figure 1-1)

- There are a high number of members per pediatrician when compared to primary care and specialty practitioners. Other access to pediatricians will be monitored to ensure that members are able to meet their health service needs. (Figure 1-2)

- 21% of transportation requested were not approved or delivered. The Department is currently investigating the measure results. (Figure 1-4)

- The first calendar quarter of 2014 over half of the ED visits per 1000 members were potentially treatable in a primary care setting. (Figure 1-7)

Customer Experience of Care
Notable Results

- Member calls are being answered quickly and within MCM contract standards. (Figure 2-2)

- The June and July indicators for new member calls and increases in hold time demonstrate increasing trends that may reflect the transition of Meridian members into new health plans. Additionally the Department is investigating other reasons for increasing hold times. (Figure 2-3)

Provider Experience of Care
Notable Results

- Provider claims are being paid quickly, accurately and within MCM contract standards. (Figure 3-1)

- Pharmacy claims are not being paid as quickly as the contract standard requires. Pharmacy claims processing is below the contract standard but continues to trend upward. For the first three months of the MCM program, most pharmacy claims were process based on previous fee-for-service Medicaid program approvals. After the first three months, the MCOs approved all pharmacy claims. This indicator will be closely monitored. (Figure 3-2)

- Provider hold times are trending upward and may reflect the transition of Meridian members into new health plans. Additionally the Department is investigating other reasons for increasing hold times. (Figure 3-5)

Utilization Management Notable Results

- Urgent and routine service authorizations are being processed within MCM contract standards. (Figure 4-1 & 4-2)

- Pharmacy authorizations are not being processed within MCM contract standards. This has been discussed with the MCOs. Ad hoc May data from the MCOs shows an upward trend and improvement for this measure. (Figure 4-3)

- The number of grievances is increasing over time. 57% of the grievances in the first quarter were related to transportation and pharmacy concerns. This upward trend is in part due to members redirecting their concerns to the MCO and not DHHS. The Department is currently engaged in a quality review of pharmacy appeals and grievances. The Department will continue to closely monitor this trend. (Figure 4-4)

Grievances and Appeals
Notable Results

- The number of appeals by category of service will be trended in future reports. (Figure 5-1)

- Grievances and appeals (standard and expedited) are being resolved within MCM contract standards. (Figure 5-3 & 5-4)

Behavioral Health Care
Notable Results

- Members discharged from New Hampshire Hospital are not seeing providers within 7 days. Improving follow up with providers is a focus of a Performance Improvement Project that is outlined in the MCM contract. (Figure 7-2)

Key Issues Update

Focus Areas

1. **Service Authorization for Therapies (PT/ST/OT)**
2. **Authorization for medications (pharmacy)**
3. **Meridian Health Plan Transition**

Service Authorizations for Therapies

- Review of medical necessity and assuring appropriate application of policy
- Data requested and received to scope challenge
- MCO A data from June to July
  - 1,112 service authorization requests
    - ~9% or 97 denied
- MCO B data from December to July
  - 1,633 service authorization requests: children only
    - ~6.5% or 106 denied
- RSA 171-A
  - DHHS review of statute, consulted with AG Office

Pharmacy Authorizations

- Still a work in progress
- DHHS requested data from MCOs
- Currently analyzing data file with 8,000 rows of data
- Target the end of September for assessment and conclusions
  - Assure appropriate fidelity to State and Plan PDL
  - Intersect and integration of State and Plan PDL
  - Review of denial reasons and notices sent to members and providers for accuracy and timeliness

MHP Transition

- **As of August 1, all MHP members have migrated to a new health plan (31K).**
- **Transition was successful and fairly seamless for members, monitoring will continue.**
- **Many data exports created to ensure continuity of care through the transition.**
- **High touch care coordination and transition planning has occurred in partnership between MHP, DHHS and the receiving MCO for individuals who are at a critical period in their treatment as well as for pregnant women.**
- Monitoring claims payments due to providers
  - Crossover claims

Issues Resolution

- Every complaint is taken seriously at the MCO and DHHS level.
- It is imperative that reported issues have sufficient detail
- Providers and members should avail themselves of grievance and/or appeal for the fastest possible resolution
- Both MCO grievances and appeals can be expedited when the situation merits.
- Collectively need to redirect members and providers to the MCO or DHHS.
- The processes in place comply with applicable laws, rules and policy but must be used to realize their potential.

NH HEALTH PROTECTION PROGRAM
&
OTHER UPDATES

NH HPP MCM Implementation

- Key Dates
  - July 1 Enrollment began
  - August 1 HIPP Cost Effectiveness began
  - August 15 Coverage under for fee for service implemented
  - September 1 MCM coverage began
  - Premium Assistance Waiver
    - Target date for Waiver Submission is 12/1/2014

NHHPP MCM Implementation

- Readiness Reviews conducted on August 13 & 15.
- Provider forums are underway and are very well attended. Forums will continue into September.
- NHHPP fee schedule has been posted to the Xerox webpage.
- Communications to potentially eligible individuals is ongoing
  - 38,000 Letters sent in past week

NH HPP Update
COB 9/3/2014

- Recipients
  - 13,654 enrolled
- Benefit Plans
  - 12,647 are in the ABP (Alternative Benefit Plan)
  - 847 of Medically Frail are in the ABP
  - 160 of Medically Frail in standard Medicaid
- Care Management / HIPP
  - 601 are Potential HIPP
  - 4,090 are enrolled in WSHP
  - 3,747 are enrolled in NHHF
  - 5,216 are in Fee For Service/not yet enrolled in a plan

Premium Assistance Waiver Update

- Third phase of NHHPP program is Premium Assistance Program
  - Transition population from managed care coverage to Qualified Health Plans on FFM
    - Target January 1, 2016
  - SB 413 requires a waiver submitted to CMS by December 1, 2014
  - DHHS must brief the Joint Health Reform Oversight Committee
  - Public notice on the draft waiver by October 1, 2014
  - DHHS will brief the MCAC and the Commission in the October meetings on the key features of the waiver request
  - Essential that we get approval of the waiver by March 1, 2015

1115 Waiver
Building Capacity for Transformation

- Application was submitted to CMS at the end of May 2014
- Since that time, DHHS having discussions with CMS on the transformations and initiatives we seek to fund
- Recent guidance by CMS requires State to demonstrate how it will change delivery and payment systems with new Federal funding

Questions?